Wisconsin Department of Safety and Professional Services

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BOARD OF NURSING

INFORMATION FOR COMPLETING CERTIFICATION OF ADVANCED PRACTICE NURSE PRESCRIBER APPLICATION FORM

REQUIREMENTS:

An applicant for initial certification as an advanced practice nurse prescriber shall be granted a certificate by the board if the applicant complies with all of the following:

1. Submits an application form (**#2124**) and fee.
2. Provides evidence of holding a current license to practice as a professional nurse in this state or has a current license to practice professional nursing in another state which has adopted the enhanced nurse licensure compact.
3. Provides evidence of current certification by a national certifying body approved by the board as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, or clinical nurse specialist.
4. Provides evidence of a master's or doctoral degree in nursing or a related health field granted by a college or university accredited by a regional accrediting organization approved by the Council for Higher Education Accreditation. This subsection does not apply to those who received national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, or clinical nurse specialist before July 1, 1998.
5. Provided evidence of completion of 45 contact hours in clinical pharmacology or therapeutics within 5 years preceding the application for a certificate.
6. Provides evidence of passing a jurisprudence examination for advanced practice nurse prescribers.

COMPLETING THE APPLICATION PROCESS:

To apply for a credential we only need to receive the application (**Form #2124**) and fee to start a file for an applicant on our system. Not all requirements below need to be complete or submitted in order to apply for a credential; they just need to be completed and submitted in order for us to issue a credential.

1. **Application (Form #2124):** Complete the application in its entirety, attach the appropriate fee, and submit to the Department at the address listed above.

2. **Certification of Master's or Doctoral Degree (Form #2367):** (not required for Re-Registration applicants)

   Complete and forward to the college or university at which you received your master's or doctoral degree. This form must be returned directly from your school to the Board of Nursing or email to DSPSCredNursing@wisconsin.gov. The Board will reject forms received from the applicant. If the school you graduated from is closed, contact the Department of Public Instruction in the state where you graduated to determine where the records for the closed school were transferred.

3. **Verification of your current national certification as a Nurse Practitioner, Certified Nurse-Midwife, or Clinical Nurse Specialist:** Contact your national certifying body to request verification sent directly to the Board of Nursing or email to DSPSCredNursing@wisconsin.gov.

4. **Verification of Licensure:** We require verification from each state in which you have ever held or currently hold prescriptive authority. Contact each state board to request a verification of licensure be sent to Wisconsin. The verification must be returned directly to the Board of Nursing via mail or email to DSPSCredNursing@wisconsin.gov. The Board will reject verifications received from the applicant.

5. **Jurisprudence Exam (WI Statutes and Rules Exam):** All candidates are required to successfully complete an online, open book exam on the Wisconsin Statutes and Rules relating to the practice of Advanced Practice Nurse Prescribers. Applicants cannot take this exam until after an application has been received and processed by the Department. Once your initial application has been processed, your exam information will be given on your application checklist online under "Wisconsin Statutes and Rules Online Exam." Your exam results will be manually posted to your online checklist. Please allow at least 10 business days from the date you finish your exam for this posting to be completed.

6. **Malpractice Insurance Coverage:** Advanced Practice Nurse Prescribers who prescribe independently shall maintain in effect malpractice insurance. Advanced Practice Nurse Prescribers who do not carry personal liability insurance coverage, must complete (**Form #2157**) to provide the type of coverage provided under a group policy. Please review the Advanced Practice Nurse Prescriber Application Information (**Form # 2151**) to determine your coverage.

7. **45 Contact hours in clinical pharmacology/therapeutics within five (5) years preceding this application:** Contact hours for academic courses are assigned as follows: one semester credit = 15 contact hours; one-quarter credit = 10 contact hours. Submit copies of all certificates of completion, or transcripts of courses attended within the last five (5) years, including the date the courses were taken. Transcript does not need to be official.

   If you do not have 45 contact hours and need assistance finding possible hours, your national certifying body would be the best resource to contact.

   "Clinical Pharmacology/Therapeutics" as defined in Wis. Admin. Code N 8.02(4) means the identification of individual and classes of drugs, their indications and contraindications, their likelihood of success, their side-effects and their interactions, as well as, clinical judgment skills and decision-making, based on thorough interviewing, history-taking, physical assessment, test selection and interpretation, pathophysiology, epidemiology, diagnostic reasoning, differentiation of conditions, treatment decisions, case evaluation, and non-pharmacologic interventions.

ANNUAL NOTIFICATION OF MALPRACTICE INSURANCE

Every Advanced Practice Nurse Prescriber who is certified to issue prescription orders shall annually submit to the Board of Nursing by October 1st of each year, satisfactory evidence that he or she has in effect malpractice insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 for all occurrences in one year.

NOTICE

No person may practice or attempt to practice as an Advanced Practice Nurse Prescriber, or use the title Advanced Practice Nurse Prescriber, or append to his or her name the letters A.P.N.P. or otherwise indicate that he or she is certified to practice as an Advanced Practice Nurse Prescriber unless he or she is currently certified under Wis. Stat. § 441.16(2).

If an application file does not have any activity for one year or more, it may be abandoned/withdrawn on our system without notification to the applicant. It is recommended to complete the application process in a timely fashion to ensure this does not happen.

U.S. DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION INFORMATION

The DEA has authorized the issuance of mid-level practitioner registration numbers to Certified Advanced Practice Nurse Prescribers (APNPs). APNPs who anticipate that their practice will include preparing prescription orders for controlled substances will be required to register with the DEA on forms provided by that agency. Forms may be ordered from the DEA at https://www.deadiversion.usdoj.gov/webforms/orderFormsRequest.jsp.

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BOARD OF NURSING

APPLICATION FOR CERTIFICATION AS AN ADVANCED PRACTICE NURSE PRESCIBER

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stats. § 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, telephone and electronic address are available to the public. Check box to withhold this information from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ __ / __ __ / ____

Social Security # ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ American Indian or Alaskan ☐ Hispanic
☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander ☐ Other

Sex: ☐ M ☐ F

Email Address

Have you ever been licensed in Wisconsin as an Advanced Practice Nurse Prescriber? ☐ Yes ☐ No

If yes, list your credential number.

List your state of primary residence: ('Primary State of Residence' is defined as the state of a person's declared fixed permanent and principal home for legal purposes; domicile.) __

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence? ☐ Yes ☐ No

Do you hold a current Wisconsin License as a Registered Nurse? ☐ Yes ☐ No

If yes, list your WI RN credential number.

I am currently Certified as: (check one)
☐ Certified Registered Nurse Anesthetist
☐ Nurse Practitioner (list specialty)
☐ Certified Nurse-Midwife
☐ Clinical Nurse Specialist (list specialty)

Master's/Doctoral Level Nursing School Name

School Address (street, city, state)

Date of Graduation or Completion of Program __ __ / __ __ / ____

Type of Degree

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)

☐ **Initial Applicants**
$ 73.00 Initial Credential Fee
$ 75.00 State Law Exam
$148.00 Total Fee Attached

☐ **Re-Registration Applicants**
$ 73.00 Renewal Fee
$ 25.00 Late Renewal Fee
$ 75.00 State Law Exam
$173.00 Total Fee Attached

For Receipting Use Only (33)

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- ☐ Application (**Form #2124**) and appropriate fee
- ☐ Verification of current National Certification
- ☐ If you received National Certification after 7/1/98, complete Certification of Master's or Doctoral Degree (**Form #2367**). This does not apply to re-registration applicants.
- ☐ Wisconsin Statutes and Rules Exam
- ☐ Proof of Malpractice Insurance Coverage (**Form #2157**)
- ☐ Letters from all State Boards where licensed, active and inactive
- ☐ Convictions and Pending Charges (**Form #2252**), if applicable
- ☐ Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- ☐ 45 contact hours in clinical pharmacology/therapeutics
- ☐ Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

ARE YOU A VETERAN? If yes, please view the Department website at http://dsps.wi.gov under "License, Permits, and Registrations" and select "Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: _____

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No
If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No
If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at http://dsps.wi.gov and select the "Professional Credential Renewal Information."

DO YOU OR HAVE YOU EVER-HELD PRESCRIPTIVE AUTHORITY IN ANOTHER STATE(S)? ☐ Yes ☐ No
If yes, list state(s) below:

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Board of Nursing. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS: (attach additional sheet(s) if necessary)

1.	Have you ever had a finding of abuse or misappropriation placed against you on the Wisconsin Nurse Aide Registry of the Department of Health, or any other State's registry? **If yes, give details on an attached sheet, including date and type of action**.	☐ Yes ☐ No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	☐ Yes ☐ No
4.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No
6.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
7.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No
8.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
9.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No
10.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice Advanced Practice Nurse Prescriber" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned Advanced Practice Nurse Prescriber judgments and to learn and keep abreast of Advanced Practice Nurse Prescriber developments; and
2. The ability to communicate those judgments and Advanced Practice Nurse Prescriber information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform Advanced Practice Nurse Prescriber tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS (attach additional sheet(s) if necessary)

11.	Do you have a medical condition, which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? If no, you may skip questions 12 and 13. **If yes, please explain.**	☐ Yes ☐ No
12.	If yes to question 11, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain**.	☐ Yes ☐ No
13.	If yes to question 11, are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	☐ Yes ☐ No
14.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice nursing with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☐ No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☐ No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No
17.	If yes to question 16, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT:

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: ____ / ____ / ____